PHYSICIAN ORDERS

1. AGENCY NAME	2. MONTH/YEAR through MONTH/YEAR
	through

3. ROUTINE MEDICATIONS	

4. PRN MEDICATIONS	

5. LABS

6. MAY HAVE ANNUAL TB TEST:		YES		NO	
7. DIET					
8. RESTRICTIONS:					
9. ACTIVITY:					
10. ADAPTIVE EQUIPMENT:					
11. MAY HAVE ANNUAL FLU VACCINE:		YES		NO	
12. MAY HAVE ADULT IMMUNIZATIONS:		YES		NO	
13. MAY HAVE PNEUMOVAX:		YES		NO	DATE:
14. MAY HAVE MEDICAL CONSULTANTIONS AS INDICATED:		YES		NO	
15. MAY INITIATE MEDICATIONS ORDERED BY CONSULTING PHYSICIAN:		YES		NO	
16. May perform routine nail care as needed					
17. I have reviewed this medical plan of care and medication regimen and approve it for the next					
	Days.				
PHYSICIAN REVIEW SIGNATURE AND DATE:					
18. AGENCY RN REVIEW SIGNATURE AND DATE:					
19. CONSUMER NAME:					ID#:
20. DATE OF BIRTH:					
21. ALLERGIES:					